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Issue Date: 22 May 2003

Case Nos: 1999-LHC-02277
2001-LHC-00432

In the Matter of

JUAN ALMANZAR,
Claimant

v.

BRADY MARINE REPAIR COMPANY, INCORPORATED,
Employer,

CIGNA,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

Jorden N. Pedersen, Jr., Esquire
For the claimant

Keith L. Flicker, Esquire
For the employer/carrier

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER ON REMAND — AWARDING BENEFITS

This proceeding arises from two claims for workers' compensation benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901 *et seq.* (hereinafter "the LHWCA" or "the Act"). The instant case comes before this Court on remand from the Benefits Review Board.

The findings of fact and conclusions of law set forth in this decision are based on my analysis of the entire record. Each exhibit and argument of the parties, although perhaps not mentioned specifically, has been carefully reviewed and thoughtfully considered. References to ALJX, EX, and CX pertain to the exhibits of the administrative law judge, employer, and claimant, respectively. The transcript of the hearing is cited as Tr. and by page number.

I. FINDINGS OF FACT

A. Procedural History

On October 22, 1991, Mr. Almanzar filed a claim for compensation under the Act against Brady Marine Repair Company, Incorporated (hereinafter "Brady Marine") based on injuries Mr. Almanzar allegedly sustained on May 14, 1991 in a work-related accident. (CX 1). The accident occurred at Brady Marine's Trumbull Street facility in Elizabeth, New Jersey when Mr. Almanzar was struck by a company truck while welding. (CX 1). In his October 1991 complaint, Mr. Almanzar alleged injury to his head, a fractured jaw, loss of two teeth, loss of vision in his left-eye, permanent injury to his back and shoulder, as well as neurological, neuropsychiatric and opthalmologic complaints. Mr. Almanzar received temporary total disability benefits from Brady Marine from May 15, 1991 through April 26, 1996, at which time benefits were terminated. (CX 13). He received $464.96 per week for 258.4 weeks for a total of $120, 164.09 in temporary total disability benefits.

On December 7, 1994, Mr. Almanzar filed a second claim for benefits under the Act, alleging he suffers from an occupational pulmonary condition caused by his exposure to dust, fumes, asbestos, and other deleterious fumes and substances while employed at Brady Marine. (CX 18). By Order dated November 20, 2000, I consolidated Mr. Almanzar's two claims.

Following proper notice to all parties, a formal hearing was held on December 12, 2000 in New York. The parties stipulated that Mr. Almanzar was involved in a work-related accident on May 14, 1991; that Claimant and Employer were in an employer/employee relationship at the time of the accident; that the injuries Mr. Almanzar sustained during the accident arose out of, and in the course of, Mr. Almanzar's employment with Brady Marine; that the claim was timely filed, noticed, and controverted; and that Mr. Almanzar received temporary total disability payments from Brady Marine in the amount of $464.98 for 258.42 weeks from May 15, 1991 through April 26, 1996 which totaled $120,164.09; and, that Claimant's average weekly wage at the time of the accident was $697.47.

On May 31, 2001, I issued a Decision and Order awarding benefits to Claimant. I found Claimant covered by the Act and the claim within my jurisdiction. I determined that, although the preponderance of the evidence failed to establish that Claimant suffered from chronic obstructive pulmonary disease arising out of the course of his employment with Brady Marine, it did prove the existence of permanent orthopaedic and psychiatric injuries. I found the extent of Claimant's injuries to be partial, and I awarded benefits accordingly.

Upon appeal, the Benefits Review Board affirmed my jurisdiction, coverage, and pulmonary findings. The Benefits Review Board also affirmed my finding that Claimant is permanently disabled after reaching maximum medical improvement on November 6, 1995. The Board remanded the case, however, to address the extent of Claimant's orthopaedic and psychiatric injuries and the presence and effect of pre-existing injuries.

B. Issues

Upon remand, the following issues remain for resolution:

1. whether Claimant's injuries are totally or partially disabling; and

2. whether Claimant possessed pre-existing injuries which reduce Employer's potential liability?

The medical and vocational evidence as summarized in the May 31, 2001 Decision and Order - Awarding Benefits, to the extent not discussed herein, is incorporated by reference into this Decision and Order on Remand.

II. CONCLUSIONS OF LAW

A. Nature of Disability - Total or Partial

Disability is defined under the Act as an "incapacity to earn the wages which the employee was receiving at the time of the injury in the same or any other employment." 33 U.S.C. §902(10). Therefore, for the Claimant to receive a disability award, an economic loss coupled with a physical and/or psychological impairment must be shown. *See Sproull v. Stevedoring Servs. of America*, 25 BRBS 100, 110 (1991). Thus, disability requires a causal connection between a worker's physical injury and his or her inability to work. Disability is usually addressed in terms of its nature (permanent or temporary) and its extent (total or partial).

Total disability is defined as complete incapacity to earn pre-injury wages in the same work as at the time of injury or in any other employment. Under current case law, the employee has the initial burden of proving total disability. To establish a prima facie case of total disability, the claimant must show that he cannot return to his regular or usual employment due to his

work-related injury. "Usual" employment is the claimant's regular duties at the time that he was injured. *Ramirez v. Vessel Jeanne Lou, Inc.*, 14 BRBS 689 (1982). At this initial stage, the claimant need not establish that he cannot return to any employment, only that he cannot return to his former employment. *Elliot v. C & P Tel. Co.*, 16 BRBS 89 (1984). The same standard applies regardless of whether the claim is for temporary total or permanent total disability. If the claimant meets this burden, he is presumed to be totally disabled. *Walker v. Sun Shipbuilding & Dry Dock Co. (Walker II)*, 19 BRBS 171 (1986).

1. Orthopaedic Injuries

The evidence of record establishes that Mr. Almanzar suffered from a fractured left mandible and cervical, lumbosacral and right shoulder sprains or strains as a result of the May 14, 1991 accident. The Claimant was hospitalized at Elizabeth General Medical Center from May 14, 1991 to May 21, 1991 due to the injuries he sustained in the accident. (CX 2). An x-ray administered at Elizabeth General Medical Center on May 14, 1991 revealed a left mandibular angle fracture. Dr. Frederick Meiselman, a board-certified oral and maxillofacial surgeon, repaired Mr. Almanzar's fractured jaw on May 17, 1991. Dr. Meiselman rendered follow-up treatment to the Claimant until August 16, 1991, when he discharged the Claimant from active treatment with a radiographically healing mandible. (CX 3). Dr. Meiselman saw Mr. Almanzar on three subsequent occasions during 1992 and 1993. The physician removed the Claimant's mandibular bone plate on April 6, 1993 because it was interfering with the Claimant's ability to wear his lower dentures. Dr. Meiselman noted no other problems with Mr. Almanzar's mandibular function and did not render treatment to Mr. Almanzar after 1993.

Several physicians of record have opined Mr. Almanzar suffered injury to his back and right shoulder as a result of the accident at the Trumbull Street Facility. Immediately following the accident, Dr. M. Bercik diagnosed the Claimant with cervical, lumbosacral, and right shoulder sprains. (CX 2). On June 11, 1991, Dr. Andrew Hutter, an orthopaedic surgeon, diagnosed Mr. Almanzar with a right shoulder contusion and cervical, lumbar and capsular strains. (CX 7). The physician expected that Mr. Almanzar would have reached his maximum orthopaedic benefit during September 1991. The record does not indicate Mr. Almanzar's orthopaedic condition was evaluated from August 27, 1991 to November 6, 1995.

Neither Dr. Bercik nor Dr. Hutter commented on the level of orthopaedic disability from which the Claimant suffers nor did the physicians unequivocally comment on the nature of any orthopaedic disability. Drs. Martinez, Nehmer, and Steinway are the only physicians of record who have rendered opinions as to the nature and extent of the Claimant's orthopaedic disability.

Dr. Armando Martinez examined the Claimant on November 6, 1995. (EX 1). During his examination, Claimant complained of: 1) constant sharp pain in the left side of the head; 2) memory loss; 3) difficulty concentrating; 4) difficulty chewing; 5) constant pain in the neck and right arm; 6) difficulty raising his arm over his head; 7) problems turning his head; 8) constant

back pain; and 9) loss of balance. Dr. Martinez stated that if the history reported by Mr. Almanzar was factual, his injuries "could very well be related to" the May 14, 1991 accident. Upon examination, the doctor concluded the Claimant had reached the maximum medical benefit of orthopaedic care. Dr. Martinez opined further orthopaedic care was not necessary and stated Mr. Almanzar suffers from a 2.5% permanent orthopaedic disability. He concluded that Mr. Almanzar is capable of working as a welder from an orthopaedic standpoint.

On August 6, 1996, Dr. Mitchell Steinway, a board-certified surgeon, evaluated Claimant and reviewed various medical records addressing Claimant's physical and psychological injuries. (CX 14). The doctor recorded the events surround Claimant's injuries on May 14, 1991, and he noted that Claimant relayed the following orthopaedic complaints during the examination: neck pain and stiffness, low back pain and stiffness, and right shoulder pain and stiffness and weakness. Claimant also complained of the following non-orthopaedic symptoms: mandibular pain, headache, intermittent radicular pain from low back to left leg, and clicking and stiffness around "left TM joint." Dr. Steinway recorded his physical examination observations in his report. Dr. Steinway diagnosed residual post-traumatic cervical and lumbar sprains, probable cervical and lumbar osteoarthritis, and a right shoulder rotator cuff tear; however, he did not provide any bases for his diagnoses. The doctor concluded that due to Claimant's orthopaedic dysfunction, coupled with his history of hypertension, his insulin-dependent diabetes mellitus, his pulmonary and psychiatric dysfunction, and residual discomfort in the mandible, Claimant is totally and permanently disabled from returning to his usual work as a welder/longshoreman. During a January 4, 2000 examination, Dr. Steinway offered the same diagnoses and conclusions as to the extent of the Claimant's disability.[1] He also stated that his physical examination observations were unchanged from his prior examination. Dr. Steinway stated he expects "no material improvement" in Mr. Almanzar's orthopaedic condition in the future and attributed the Claimant's condition to the May 14, 1991 accident. In a supplemental report dated January 28, 2000, Dr. Steinway offered an identical diagnosis after reviewing additional medical records.

During his October 24, 2000 deposition, Dr. Steinway explained how he arrived at the diagnoses of probable cervical and lumbar osteoarthritis and a right shoulder rotator cuff tear. (CX 22). The physician first discussed his August 6, 1996 examination of the Claimant. Dr. Steinway noted the Claimant's neck was stiff on physical examination and the trapezius muscles between the Claimant's shoulders and neck were tender and had abnormal spasm or tightness of the muscle. (CX 22, pp. 8-9). Dr. Steinway stated muscle spasms may be caused by nerve, spinal cord or head injuries, as well as local causes such as direct injury, an infection or a tumor. Dr. Steinway also testified Mr. Almanzar had clinical and historical complaints consistent with a tear of the right rotator cuff, a group of our tendons which help to control the motion of the shoulder. (CX 22, p. 10). The physician noticed the Claimant had atrophy on the right side of the deltoid muscle and the supraspinatus muscles. He explained a finding of atrophy indicates a patient's muscles either are not being used or are not being stimulated. According to Dr. Steinway, the

[1] In his January 4, 2000 report, Dr. Steinway references his February 10, 1998 examination report. No such report is found in the record.

causes of atrophy can be local, such as when a person's joint hurts and the person will not move it, or distant, when nerves compress muscles and they die away. (CX 22, p. 11). The physician stated approximately 50% of the Claimant's shoulder motion was missing in 1996. The doctor stated when he tried to move Mr. Almanzar's right arm out forward from Mr. Almanzar's torso, he could only lift the arm to 90 degrees, whereas a normal range of motion would be 180 degrees. Dr. Steinway noted that he considered the range of motion tests he performed on the Claimant to be accurate because they did not indicate the Claimant was restricting his ability to move his spine or shoulder in any position. (CX 22, p. 15). The physician noted localized tenderness and a complaint of pain on palpation in the area where the rotator cuff inserts into the top of the humerus. (CX 22, p. 12). On passive motion, the physician heard a crepitus or grinding sensation, which the physician opined is a sign of a rotator cuff disease or tear which was consistent with the five-year interval between the accident and the examination because such a finding usually develops after several years. The physician also noted a decreased curvature in the lumbar spine on physical examination. The physician explained that a finding of a straight spinal cord is consistent with osteoarthritis and/or cervical disk disease. He stated such a finding can be caused by muscle spasm or an arthritic change. The physician determined the Claimant had 50% loss of the normal lumbar motion for someone his age. Dr. Steinway noted Mr. Almanzar's reflexes were sluggish, which indicated he was having some early interference with the muscle group that was tested reflexively. (CX 22, p. 13). Dr. Steinway considered such a finding to be an early sign of nerve root compression.

Dr. Steinway diagnosed the Claimant with residual post-traumatic cervical spine sprain, probable cervical osteoarthritis, residual post-traumatic strain of the lumbar spine, probable lumbar osteoarthritis, and right shoulder rotator cuff tear. (CX 22, p. 15). The physician explained a sprain is an "injury or force applied to ligaments, tendons, and muscles to disrupt the normal anatomy of that structure and to cause them to heal in an abnormal position that alters the mechanics of the joints involved. The physician stated a sprain results in a stretched or partially torn muscle which heals with scar tissue and may entrap nerve fibers, thus permanently altering the muscle and impairing the functioning of the muscle. (CX 22, p. 16). Dr. Steinway testified that Mr. Almanzar had pre-existing osteorarthritis of the spine because x-ray reports very close in time to the May 1991 accident showed radiological signs of osteoarthritis and because he noted findings consistent with osteoarthritis on clinical examination of the miner. Specifically, the physician stated that in his eighteen years of clinical experience, an individual who has restricted cervical spine motion, passively, in multiple planes; complaints of persistent neck pain; and a straightening of the cervical curvature or cervical lordosis, will have cervical osteoarthritic changes on x-ray. (CX 22, p. 17). Dr. Steinway stated the effect of a sprain can be different where an individual suffers from osteoarthritis of the cervical and lumbar spine. The physician explained osteoarthritis causes stiffness and resulting abnormal functioning of the back and neck. He stated if soft tissue abnormalities to muscles and ligaments are superimposed on the bony abnormalities, it will exacerbate and accelerate the disability or abnormal function that the individual already had from the bony injury. (CX 22, p.16-17). The physician concluded Mr.

Almanzar's orthopaedic conditions are permanent in nature and that the Claimant was permanently and totally disabled from an orthopaedic standpoint for his usual work as a welder and a longshoreman. (CX 22, p. 17).

Dr. Steinway testified that he examined the Claimant again on February 10, 1998. (CX 22, p. 18).[2] The physician noted the same physical findings he noted during the 1996 examination. The physician also noted an additional finding of atrophy in the left thigh versus the right thigh. (CX 22, p. 21). Dr. Steinway stated atrophy of the left thigh can be caused by a joint problem in the hip, knee, or ankle. The physician stated it was more likely the atrophy represented a mild nerve root compression in the sciatic area. Dr. Steinway noted the atrophy was only 1 centimeter which is the lowest amount that can be measured in the office, however, he felt atrophy was present. (CX 22, p. 22). The physician also noted the Claimant was walking with an abnormal gait: Claimant was hunched over a bit with his torso bent forward about 20 degrees. The physician also noted a decrease in straight leg raising, and some bursal thickening around the right shoulder. Dr. Steinway testified there was a "small but definite degree of increased abnormal physical findings in 1998 versus 1996." Dr. Steinway made the same diagnoses he made during the 1996 examination. (CX 22, p. 23). The physician again opined Mr. Almanzar is totally and permanently disabled from his usual work activity as a welder and a longshoreman, noting that the Claimant's orthopaedic condition was "essentially the same."

Dr. Steinway testified he also examined Mr. Almanzar on January 4, 2000. (CX 22, p. 24). The physician stated he found no significant changes concerning the cervical spine, thoracic spine, lumbar spine or right shoulder since the 1998 examination. (CX 22, p. 25). The physician's diagnoses and opinion as to the nature and extent of the Claimant's orthopaedic disability stayed the same. The physician reviewed additional medical records on January 28, 2000, but those records did not alter his opinions. Dr. Steinway opined that the injuries the Claimant sustained during the May 1991 accident aggravated and accelerated the Claimant's pre-existing osteoarthritis of the neck and back; however, the physician noted the osteoarthritis was not symptomatic at the time of the injury. Dr. Steinway further opined the accident "aggravated and accelerated pre-existing cervical disk disease and osteoarthritis, causing it to become symptomatic and interfere with upper and lower extremity orthopaedic function and also was the sole contributor to the severe injury of the right shoulder, causing the right shoulder to become dysfunctional." (CX 22, p. 27). Thus, Dr. Steinway concluded the orthopaedic injuries are a substantial contributing factor to the Claimant's total orthopaedic disability.

On cross-examination, Dr. Steinway distinguished the diagnosis of a patient from the assessment of a patient's disability, stating the two are independent. (CX 22, p. 30). He stated the history a patient gives him does not materially affect the amount of disability he will find because a finding of orthopaedic disability is based on a patient's inability to perform certain maneuvers, i.e. walking, sitting, bending, moving a joint, etc. The physician stated his reports do not indicate

[2] *See supra* note 1.

and he does not recall the Claimant being uncooperative or exaggerating his condition. (CX 22, p. 33). When asked whether psychiatric medication Mr. Almanzar was taking would have affected his reflexes, Dr. Steinway stated he would have to know the exact medication because psychotropic medications generally do not dampen the peripheral reflexes of the arms and legs. (CX 22, p. 35). The physician stated the cervical spine injury could also affect the Claimant's arm reflexes. (CX 22, p. 36). He explained if there is nerve compression of the sixth or seventh cervical nerve root, it will make the biceps and triceps reflexes at the elbow sluggish. However, Dr. Steinway found no other evidence of nerve root compression in the cervical spine. He did not review the actual x-ray films upon which he based the osteoarthritis diagnosis. (CX 22, p. 39). The physician also was not aware of any MRI studies performed on the Claimant's cervical and lumbar spine.

Dr. Steinway acknowledged he is the only physician of record who diagnosed a right rotator cuff tear and stated the other orthopaedic physicians missed the diagnosis. (CX 22, p. 42). The physician testified that he related the persistent muscle spasm to the Claimant's accident because the accident caused the injuries which caused aggravation and acceleration of the Claimant's disk disease and osteoarthritis and secondarily by nerve compression to various muscles. (CX 22, pp. 47-48). The physician stated the muscle spasm is another symptom of nerve root compression because the atrophy of the deltoid and supraspinatus muscles could be caused by nerve root compression over time or by disuse of the muscle. (CX 22, p. 48). Dr. Steinway initially stated Mr. Almanzar's orthopaedic conditions prevent him from working; however, the physician also stated that "from an orthopaedic point of view, if a job could be structured so that he would not have any heavy lifting, he would be able to get up from a bench type situation ten minutes every hour to walk around and stretch, that he would not have to use his right upper extremity repetitively in an overhead manner, it is possible that some light duty job could be constructed" for the Claimant. (CX 22, pp. 51-52).

Dr. Steven Nehmer, board-certified in orthopaedic surgery, examined Mr. Almanzar on May 25, 2000. (EX 2). The doctor's physical examination observations are included in his report. Although the Claimant complained of back, neck, and right shoulder pain, Dr. Nehmer concluded the Claimant was engaging in symptom magnification. Dr. Nehmer thought Mr. Almanzar exhibited more subjective complaints than objective findings. The doctor acknowledged Mr. Almanzar sustained cervical, lumbar and right shoulder strains in the May 14, 1991 accident; however Dr. Nehmer opined Mr. Almanzar had fully recovered from those injuries and required no further testing or treatment. Dr. Nehmer further opined that Mr. Almanzar could perform the job of a welder from an orthopaedic standpoint. Dr. Nehmer defended his conclusions in a pre-hearing deposition conducted on December 1, 2000. (EX 14).

Counsel for the Employer deposed Dr. Nehmer on December 1, 2000. (EX 14). Dr. Nehmer is board-certified in orthopaedic surgery. The physician testified he performed an examination on the Claimant on May 25, 2000. The physician testified his clinical examination of the Claimant focused upon his neck, back and right shoulder. Based on his review of the records, the

physician stated the Claimant's ability or range of motion he exhibited in his neck was not consistent with the injuries he sustained in the work accident. Dr. Nehmer stated he has seen patients with neck fractures, multiple disk herniations and neck tumors who are able to move their necks more than Mr. Almanzar did. He stated there is "really almost no explanation of having that little motion in your neck." Dr. Nehmer also noted he found no atrophy in the Claimant's upper or lower extremities. The physician explained problems in the neck can result in atrophy in the upper extremities and problems in the back can result in atrophy in the lower extremities. The physician found Mr. Almanzar to have better than average muscle tone in his body. He stated if one has a significant loss of motion and the amount of pain Mr. Almanzar was exhibiting, the person would be expected to have a very significant amount of atrophy because one would not use an extremity if he or she could not do so. Dr. Nehmer found no spasm on neck palpation and stated he would only expect to find such weeks or possibly even months after an injury, but not years afterward. Dr. Nehmar reiterated his diagnoses of cervical strain, lumbar strain, and right shoulder sprain caused by the 1991 accident. The physician opined the Claimant had completely recovered from those injuries. Dr. Nehmer concluded the Claimant could work as a welder from an orthopaedic standpoint. The physician indicated he considered the work of a welder to be "heavy" work. Dr. Nehmar stated the Claimant requires no further testing or treatment for his orthopaedic injuries. The physician didn't record the results of other range of motion tests such as the tests for flexion, extension, and tilt. Dr. Nehmer did not perform tests of internal and external rotation on the right shoulder and these tests are some of the clinical tests used to determine whether someone has a tear of the rotator cuff. Dr. Nehmer admitted not everyone who has subjective complaints without objective findings is guilty of symptom magnification. The physician explained that he thought Mr. Almanzar was engaging in symptom magnification because of the way he described his injuries, the way he attempted to move various body parts when asked to do so, the Claimant's facial expressions, his reactions when Dr. Nehmer touched him in certain places, i.e., saying it hurts a lot, but no involuntary motion or reflex facial reaction one would normally get with a person who has just experienced something painful to them. Dr. Nehmer did not suspect the Claimant had a torn right rotator cuff. He stated if an orthopedist suspects a torn rotator cuff, the physician should order a diagnostic test such as an MRI to determine the presence of such a condition. He stated a diagnosis of a torn rotator cuff cannot be made without the benefit of a diagnostic test. Dr. Nehmer stated he saw no evidence of decreased lordosis or nerve root compression in the cervical or lumbar spine. Dr. Nehmer examined the Claimant without the benefit of any diagnostic films, but stated a cervical spine x-ray in the Elizabeth General Medical records and a lumbar spine x-ray in Dr. Hutter's June 17, 1991 report did not change his opinions.

I grant no weight to Dr. Martinez's brief opinion because his report fails to specifically diagnose even one physical impairment or restriction suffered by Claimant. Dr. Martinez proffers only summary conclusions. He records his observations for the head, face, neck, right arm, and lumbo sacral spine examinations he administered, but he offers no final opinion concerning Claimant's physical impairments or restrictions beyond concluding that Claimant is not totally disabled from his usual welding job. The doctor also opines that Claimant suffers from a 2.5%

permanent orthopaedic disability, but he provides no rationale or supporting data to explain his disability opinion. Due to the doctor's failure to provide explicit support or rationales for his medical conclusions, I grant his opinion less weight.

Although Drs. Steinway and Nehmer are both highly-qualified physicians, there are several reasons why I accord greater weight to the opinion of Dr. Steinway than to the opinion of Dr. Nehmer.

First, Dr. Steinway had the benefit of examining the Claimant on three occasions during a four-year period, whereas Dr. Nehmer evaluated the Claimant only once during 2000. Dr. Steinway's additional examinations render his opinions more probative because the doctor is afforded an opportunity to 1) examine the Claimant a number of times; 2) observe his physical condition progress over time; and 3) confirm the legitimacy of Claimant's injuries over time.

Second, Dr. Steinway rendered his opinions based upon a more accurate picture of the Claimant's total medical condition than did Dr. Nehmer. Dr. Steinway was aware of the Claimant's history of myocardial infarction, hypertension, insulin-dependent diabetes mellitus, diabetic retinopathy, psychiatric dysfunction, and renal failure. In contrast, Dr. Nehmer demonstrated awareness only of Claimant's insulin-dependent diabetes mellitus and history of hypertension, and he did not demonstrate knowledge that Mr. Almanzar suffered from diabetic retinopathy or had a history of myocardial infarction. Dr. Nehmer's deposition testimony confirms that the physician did not have an accurate picture of the Claimant's overall medical condition. Dr. Nehmer testified that Mr. Almanzar had better than average muscle tone for someone his age, was an active person, and appeared to exercise regularly, at a time when the Claimant had been advised to no longer drive due to his vision loss, was receiving kidney dialysis three times per week, and was suffering from heart problems. Given the multiple medical conditions from which the Claimant suffers, I seriously question the reliability of Dr. Nehmer's assessment of Mr. Almanzar's physical appearance, muscle tone, and activity level.

Moreover, Dr. Nehmer did not document or explain the examination findings in support of his conclusions as thoroughly as did Dr. Steinway. Although Dr. Steinway is the only physician of record who diagnosed Mr. Almanzar with a torn right rotator cuff, he offered ample clinical findings to support his diagnoses. For example, Dr. Steinway, unlike Dr. Nehmer, recorded the specific values on the range of motion tests he conducted on the Claimant's back, neck and right shoulder and explained why the range of motion tests and the clinical examination findings supported his diagnosis of a torn right rotator cuff. Dr. Nehmer stated the range of motion tests he performed on the Claimant's right shoulder showed limited rotations, but did not record specific values identifying the extent of the limitation. Dr. Nehmer also criticized Dr. Steinway's diagnosis of a torn right rotator cuff because the physician stated a rotator cuff tear cannot be diagnosed without the benefit of an MRI or some other diagnostic test. However, Dr. Nehmer did not perform such a diagnostic test in ruling out the presence of a rotator cuff tear.

Dr. Nehmer's explanation of the Claimant's subjective complaints of pain and limited back, neck and right shoulder movement was that Mr. Almanzar was engaging in symptom magnification. In his May 2000 examination report, Dr. Nehmer stated he thought Mr. Almanzar was engaging in symptom magnification because he thought the Claimant had "far more subjective complaints than objective findings." The physician also stated "it did not seem as though [Mr. Almanzar] was making a true effort to move his neck, back or shoulder." During his December 4, 2000 deposition, Dr. Nehmer testified as to specific examination findings he made during his examination of the Claimant which led the physician to believe the Claimant was engaging in symptom magnification. However, Dr. Nehmer failed to note those findings in his May 25, 2000 examination report and testified that he had no independent recollection of his examination of the Claimant. Thus, I accord little weight to Dr. Nehmer's deposition testimony discussing specific examination findings not noted in Dr. Nehmer's report because the physician himself testified he had no independent recollection of his examination of the Claimant.

Conversely, Dr. Steinway testified that he considered the range of motion tests he performed on Mr. Almanzar to be accurate because the tests did *not* indicate the Claimant was restricting his ability to move his spine or shoulder in any position. I accord greater weight to Dr. Steinway's assessment of the level of effort exhibited by the Claimant on the range of motion tests because Dr. Steinway had several opportunities to evaluate Mr. Almanzar's efforts over a four-year period and thus was in a better position to more accurately determine whether the Claimant was making genuine efforts on the range of motion testing.

Dr. Steinway also opined the neck, back, and right shoulder injuries Mr. Almanzar sustained during the May 14, 1991 accident "aggravated and accelerated the Claimant's preexisting osteoarthritis and cervical disc disease, causing it to become symptomatic and interfere with upper and lower extremity orthopaedic function and was the sole contributor to the right shoulder injury and resulting dysfunction." Dr. Steinway based his diagnosis of osteoarthritis and cervical disc disease on two x-rays taken after the accident in 1991 as well as findings of restricted cervical spine motion in multiple planes, complaints of persistent neck pain, and straightening of the cervical curvature or cervical lordosis. Dr. Steinway explained that effect of a back sprain can be different in a person who suffers from osteoarthritis of the cervical and lumbar spine. According to Dr. Steinway, osteoarthritis causes stiffness and resulting abnormal functioning of the back and neck. When soft tissue abnormalities to muscles and ligaments are superimposed on the bony abnormalities caused by osteoarthritis, the disability an individual has from a bony injury will be exacerbated and accelerated. I note that when work-related injuries aggravate, exacerbate, accelerate, contribute to, or combine with a previous infirmity, disease, or underlying condition, the entire resultant condition is compensable under the Act. *See Wheatley v. Adler*, 407 F. 2d 307 (D.C. Cir. 1968).

Dr. Nehmer did not address the x-ray evidence of degenerative changes in the spine and did not comment on the presence or absence of osteoarthritis or cervical disc disease even though he indicated that he reviewed the medical records from Elizabeth General Medical Center and

Dr. Hutter. Dr. Nehmer testified that the 1991 cervical spine x-ray from Elizabeth General Medical Center was basically normal and thus furthered his diagnosis of cervical strain; however, the physician did not comment on the minimal to moderate degenerative osteoarthritic changes Dr. Whitaker noted in the cervical spine. (CX 2). Likewise, when asked about the mild degenerative changes noted on a June 17, 1991 lumbar spine x-ray administered during Dr. Hutter's examination, Dr. Nehmer testified the x-ray supported his diagnosis of a lumbar strain. However, Dr. Nehmer offered no explanation as to whether the Claimant suffered from degenerative osteoarthritic changes in his spine and offered no opinion as to whether the presence or absence of such a condition supported his diagnoses of cervical and lumbar strains. As to the existence of degenerative osteoarthritic changes in the Claimant's spine, I accord greater weight to the opinion of Dr. Steinway than to the opinion of Dr. Nehmer.

Employer argues that Dr. Steinway's 1996 opinion is not supportive of a total disability finding because Dr. Steinway's diagnosis of total disability was based upon work-related *and* non-work-related injuries. Employer is correct to note that Dr. Steinway's diagnosis of total disability in 1996 encompassed all of Claimant's physical impairments. In determining total disability, however, I am not bound my a physician's assessment of total disability. Rather, the central issue is whether the preponderance of the medical evidence establishes physical limitations from work-related injuries which prevent a claimant from returning to his or her usual work. The final assessment of total disability is for this Court to render. The fact that Dr. Steinway considered all of Claimant's injuries when providing his 1996 diagnosis does not render his opinion devoid of probative value. Dr. Steinway's diagnoses were residual post-traumatic cervical spine sprain, probably cervical osteoarthritis, residual post-traumatic lumbar spine sprain, probably lumbar osteoarthritis, and right shoulder rotator cuff tear. None of the non-work-related injuries considered by the doctor – psychiatric dysfunction, insulin-dependent diabetes, and myocardial infarction – could contribute to a residual post-traumatic cervical spine sprain, probable cervical osteoarthritis, a residual post-traumatic lumbar spine sprain, probable lumbar osteoarthritis, or a right shoulder rotator cuff tear. Furthermore, Dr. Steinway further specifies his findings when he categorizes them "post-traumatic." Accordingly, utilizing Dr. Steinway's findings to establish total disability is not inappropriate.

I find the probative value I accord to Dr. Steinway's report and deposition testimony outweighs the probative value of the reports of Drs. Nehmer and Martinez and the deposition of Dr. Nehmer. The specificity and thoroughness of Dr. Steinway's written report and deposition testimony, combined with their foundation of multiple examinations, render Dr. Steinway's opinion the most probative of record concerning Claimant's orthopaedic injuries. Thus, I find Mr. Almanzar sustained cervical and lumbar sprains due to the May 14, 1991 accident which aggravated and accelerated his preexisting osteoarthritic condition and resulted in a torn right rotator cuff and restricted back, neck, and shoulder movement. Claimant's right shoulder motion is 50% restricted, and his lumbar spine motion is 50% reduced. Claimant also suffers from sluggish reflexes because of muscle group damage. Furthermore, the evidence demonstrates that the stiffness resulting from Claimant's osteoarthritis exacerbates and accelerates the abnormal functioning of Claimant's back, shoulder, and arm.

I also find the proven work-related injuries and restrictions prevent Claimant from returning to his welding job. Claimant's restricted back, neck, and shoulder movement, combined with the effects of his cervical and lumbar sprain, torn right rotator cuff and sluggish reflexes due to muscle damage and nerve root compression, would make it impossible for Claimant to perform the bending, climbing, stooping, lifting, and squatting necessary to adequately perform a normal welding job. Claimant's restricted right shoulder and back movements seriously compromise his ability to hold tools, operate welding equipment, maneuver around welding projects, climb ladders, and move materials. Claimant's restricted neck movement narrows his range of vision, thus necessitating greater maneuverability which Claimant does not possess. The medical evidence also demonstrates that simple walking is affected by Claimant's back injuries as Dr. Steinway noted Claimant's abnormal gait and hunched walking stance. Claimant's injuries from his May 1991 accident combine to produce physical movement restriction which eliminate the ability to perform moderate to heavy labor such as welding.

Accordingly, I find Claimant has established a prima facie case of total disability due to his orthopaedic injuries.

2. Psychiatric Injuries

Mr. Almanzar also alleges he suffers from permanent psychiatric conditions because of the May 14, 1991 accident which contribute to his inability to return to work as a welder. Since the May 14, 1991 accident, Mr. Almanzar has been treated or evaluated by at least six psychiatrists: Drs. Mendelson, Castillo, Moreno, Filipone, Head, and Ferretti.

Dr. Walter M. Castillo met with Claimant five times, beginning on May 29, 1996. Claimant complained of depression, insomnia, headaches, irregular appetite, and forgetfulness. Upon examination, Dr. Castillo diagnosed Mr. Almanzar with a prolonged depressive disorder, but he did not relate the condition to the May 14, 1991 accident or any injuries arising therefrom. Dr. Castillo also offered no opinion as to the nature and extent of the Claimant's disability. (CX 12).

Dr. Mendelson, a board-certified psychiatrist and neurologist, treated Mr. Almanzar on a number of occasions from September 1991 through February 1992. (EX 7). In September 1991, Dr. Mendelson stated the Claimant's history and examination suggested a post-traumatic headache syndrome; however the physician was unable to find any organic basis for the Claimant's complaints of headaches, left facial numbness, and vision loss. Dr. Mendelson also thought Mr. Almanzar's headaches could be the result of anxiety about returning to work or depression. Dr. Mendelson treated Mr. Almanzar until February 12, 1992, when Dr. Mendelson concluded Mr. Almanzar had reached maximum medical improvement. At that time, Dr. Mendelson found no reason why the Claimant could not return to work. Dr. Mendelson's last seven reports all concluded that the doctor could find no organic basis for Claimant's alleged psychiatric problems but

rather secondary gain was a possible explanation. In his July 24, 1992 report, Dr. Mendelson commented that dental problems may be a factor in Claimant's headaches. In his final report, the doctor found no reason why Claimant could not return to work.

Dr. Moreno treated Mr. Almanzar's psychiatric condition from March 1992 through November 1993. (CX 8; EX 3). On March 13, 1992, Dr. Moreno diagnosed Mr. Almanzar with an adjustment disorder with mixed emotional features and stated amnestic syndrome and organic mood syndrome needed to be ruled out as possible diagnoses. The physician attributed the Claimant's mental status to anxiety and depression, which Dr. Moreno thought appeared to be triggered by the difficulties Mr. Almanzar had experienced since the May 14, 1991 accident. During the course of his treatment of the Claimant, Dr. Moreno noted improvement in the Claimant's mood, headaches, and symptoms. Less than two months after Dr. Moreno noted such an improvement, the Claimant began to complain of a regression in his symptoms and was concerned about Dr. Moreno possibly wanting him to return to work. At that point, Dr. Moreno became concerned that secondary gain may be an issue with Mr. Almanzar. By January 1993, Dr. Moreno concluded Mr. Almanzar was making conscious attempts to aggravate his symptoms. Dr. Moreno found the Claimant's complaints to be contradictory to his observations of the Claimant. Dr. Moreno concluded Mr. Almanzar reached maximum medical improvement on November 1, 1993 and that consideration should have been given to reintegrating the Claimant into the work force.

Dr. Richard Filippone, a clinical neuropsychologist, evaluated Mr. Almanzar's condition on August 8, 1993. (EX 8). Dr. Filippone concluded Mr. Almanzar was "faking" his psychiatric problems and cognitive deficits and was motivated by secondary gain. The physician stated he was unable to properly evaluate the Claimant's true cognitive abilities because the Claimant was not motivated to give accurate responses. Dr. Filippone found Mr. Almanzar's performance during the evaluation to be inconsistent with a head injury because of the severity of some of the Claimant's cognitive results, the inconsistency on others, and a complete lack of correlation between the Claimant's cognitive skills and his capacity to perform daily living activities. Dr. Fillippone acknowledged Mr. Almanzar may have suffered headaches following the May 14, 1991 accident; however, the physician stated the Claimant's malingering prevented him from determining the degree to which the Claimant may still suffer headaches.

Dr. Ferretti, a board-certified neurologist and psychiatrist, evaluated Mr. Almanzar's psychiatric condition on several occasions, but never rendered psychiatric treatment to the Claimant. (EX 4). When Dr. Ferretti initially examined the Claimant on May 17, 1993, he diagnosed an adjustment reaction of adult life with features of anxiety, depression, and phobia, possible neuropsychological dysfunction, and post-traumatic headaches in partial remission. The physician stated there appeared to be no psychiatric permanency and that the issue of secondary gain needed to be addressed. After an April 22, 1996 examination, Dr. Ferretti reiterated his diagnoses of an adjustment reaction of adult life with features of anxiety, depression and phobia and post-concussion headaches. The physician also stated neuropsychological dysfunction secondary to a

closed head injury with loss of consciousness needed to be ruled out as a possible diagnosis. The physician thought it would be unreasonable for the Claimant to return to work as a welder given his subjective complaints. Dr. Ferretti stated the evidence indicated Mr. Almanzar is categorically disabled. During an October 17, 2000 examination, Dr. Ferretti found Mr. Almanzar's condition to be significantly worse. I note the evidence of record indicates Mr. Almanzar's non-work related conditions began to worsen during 1998 when the Claimant went into renal failure and began receiving dialysis three times each week. On October 17, 2000, Dr. Ferretti diagnosed the Claimant with chronic depression, anxiety, sleep disturbance, phobia, a neuropsychological dysfunction secondary to a closed head injury with loss of consciousness, and post-concussion headaches with dizziness. The physician stated Mr. Almanzar is totally and permanently disabled for all work due to the deterioration in his physical condition caused by non-work related conditions such as diabetes mellitus, renal disease, coronary artery disease, and hypertension. Dr. Ferretti stated the Claimant's work-related injuries are a substantial cause of his depression . Dr. Ferretti concluded the May 14, 1991 accident is a substantial contributing cause of the Claimant's disability and inability to work. Dr. Ferretti also stated the Claimant's renal illness plays a substantial role in his psychiatric disability. Dr. Ferretti rated the Claimant's global assessment of functioning at 40, a rating Dr. Ferretti considered very low.

Dr. Head, a board-certified psychiatrist, diagnosed Mr. Almanzar as a malingerer after examining the Claimant once on July 13, 2000. (EX 5). Dr. Head diagnosed Mr. Almanzar as a malingerer and stated the Claimant was attempting to simulate psychopathology for purposes of his claim. The physician opined the Claimant's non-work related conditions prevent the Claimant from working. Dr. Head also diagnosed Mr. Almanzar with a phase of life problem. Dr. Head opined Mr. Almanzar sustained no permanent psychiatric condition or disability related to the May 14, 1991 accident. The physician stated whatever transient emotional complaints the Claimant may have initially suffered as a result of the May 14, 1991 accident have objectively resolved, without permanent psychiatric residuals." Dr. Head acknowledged the Claimant's original psychiatric complaints were likely due to the May 14, 1991 accident. Dr. Head found no reason to impose psychiatric restrictions on Mr. Almanzar's ability to work and thought vocational guidance was not necessary. The physician opined the Claimant will not experience any future worsening of his psychiatric condition. Dr. Head rated the Claimant's global assessment of function as 70, a rating which Dr. Head considered to be normal.

As discussed above, Drs. Moreno, Mendelson, Fillippone, and Head are of the opinion that Mr. Almanzar does not suffer from a disabling psychiatric condition. As early as December 16, 1992, Dr. Mendelson, the Claimant's treating psychiatrist, found no organic basis for the Claimant's psychiatric complaints and found no reason why Mr. Almanzar could not return to work. During January 1993, the Claimant's other treating psychiatrist, Dr. Moreno, thought the Claimant was trying to aggravate his symptoms and that secondary gain may be an issue with the Claimant. Likewise, Dr. Filippone concluded that secondary gain motivated Mr. Almanzar to fake his psychiatric problems and cognitive deficits. Dr. Head opined Mr. Almanzar suffers from no permanent psychiatric condition or disability because of the May 14, 1991 accident.

Dr. Ferretti is the only physician of record who has definitively opined that Mr. Almanzar suffers from a permanent psychiatric disability caused by the injuries he sustained in the May 14, 1991 accident. However, the doctor's conclusions are not without caveat. When Dr. Ferretti initially diagnosed Mr. Almanzar on May 17, 1993, he stated there appeared to be no psychiatric permanency and thought the issue of secondary gain needed to be addressed. During his April 22, 1996 evaluation, however, Dr. Ferretti stated the evidence appeared to indicate the Claimant is categorically disabled. The physician did not mention his prior finding of no psychiatric permanency or his prior concern about secondary gain. By October 17, 2000, Dr. Ferretti diagnosed chronic depression among other conditions and stated Mr. Almanzar was totally and permanently disabled due to his non-work-related conditions and work-related conditions. The physician attributed the Claimant's depression to his work-related injuries and stated renal illness plays a role in the Claimant's psychiatric disability.

Based upon my review of the evidence addressing Claimant's psychiatric injuries, I find that Claimant has not established a psychiatric disability by a preponderance of the evidence. Drs. Moreno, Mendelson, Fillippone, and Head are of the opinion that Mr. Almanzar does not suffer from a disabling psychiatric condition. Each physician, at one time, reported concerns of "faking," "secondary gain," or "malingering." I find each of the physicians' opinions well reasoned and well documented. While Drs. Ferretti and Castillo diagnosed depression, the combined probative value of their reports does not outweigh the probative value of the reports of Drs. Moreno, Mendelson, Fillippone, and Head. Compared to the other psychiatric reports, Dr. Castillo's report is brief and conclusory. Accordingly, I grant it less weight. Dr. Ferretti's report is well reasoned and well documented; however, the doctor also expressed concerns about secondary gain in some of his reports, which renders his diagnosis mixed and less definitive.

Claimant has demonstrated a prima facie case of total disability due to his work-related orthopaedic injuries suffered on May 14, 1991. Once a claimant establishes a prima facie case of total disability, the burden shifts to the employer to establish the availability of suitable alternate employment. *See Trans-State Dredging v. Benefits Review Board (Tarner)*, 731 F.2 199, 200-02 (4th Cir. 1984). The employer can establish the availability of suitable alternate employment by showing the existence of realistic job opportunities that the claimant is capable of performing, considering his or her age, education, work experience, and physical restrictions. *See New Orleans (Gulfwide) Stevedores v. Turner*, 661 F. 2d 1031 (5th Cir. 1981).

As Employer presented no evidence of suitable alternative employment, Claimant is entitled to an award of permanent total disability compensation as a matter of law. *See generally Pietrunti v. Director, OWCP*, 119 F.3d 1035, 31 BRBS 84 (CRT) (2d Cir. 1997).

B. Section 8(f) Relief

Section 8(f) of the Act provides that the Special Fund will assume responsibility for permanent disability payments after 104 weeks where an employee suffers from a manifest, pre-

existing, permanent partial disability. 33 U.S.C. §908(f)(1); *Two "R" Drilling Co. v. Director, OWCP*, 894 F.2d 748, 23 BRBS 34 (CRT) (5th Cir. 1990). Simply proving a prior disability is not enough, however; the employer must show that the second injury by itself would not have led to total disability. *See Two "R" Drilling Co.*, 894 F.2d at 750 (holding employer did not meet its burden of showing that current total disability was not due solely to employment injury because it failed to put on medical evidence to suggest that claimant's pre-existing back diseases contributed to his current total back disability); *Pennsylvania Tidewater Dock Co. v. Director, OWCP [Lewis]*, 202 F. 3d 656, 34 BRBS 55 (CRT) (3d Cir. 2000). A medical condition need not be economically disabling in order to constitute a pre-existing permanent partial disability within the meaning of Section 8(f). *See Atlantic & Gulf Stevedores, Inc. v. Director, OWCP*, 542 F.2d 602, 4 BRBS 79 (3d Cir. 1976). In order to constitute a pre-existing permanent partial disability for Section 8(f) purposes, the claimant must have a serious, lasting physical condition which pre-existed the work injury. *See Director, OWCP v. General Dynamics Corp. [Bergeron]*, 982 F.2d 790, 26 BRBS 139 (CRT) (2d Cir. 1992).

In the instant case, Employer submitted evidence of prior injuries to Claimant's back and buttocks in the form of a workers' compensation application. (EX 9). The application provided that Claimant suffered injuries to his back and buttocks and "[Claimant's] back hurts when he does any work." Employer also advances that the medical records demonstrate that Claimant also suffers from diabetes mellitus and heart disease. (Employer's Brief on Remand, p. 11; EX 13). Employer argues that Claimant's previous back injury, diabetes, and heart disease "combined with the work-related accident to create a materially and substantially greater disability than that which would have resulted from the work-related accident alone."

The lone piece of medical evidence linking Claimant's work injury and his previous injuries is Dr. Eisenstein's deposition testimony. (Employer's Post-Hearing Brief, p. 33; CX 24, p. 52). The doctor's testimony concerns Claimant's alleged pulmonary disability, not Claimant's back and shoulder injuries. While there is no requirement that the previous injury be of the same type as the work-related injury, the previous injury must impact the subsequent injury. On this point, Employer has presented no medical evidence. Employer's only evidence is Claimant's workers' compensation applications alleging a back injury, but Employer provides no proof that Claimant's alleged previous back injury contributed to his current total disability. *See Two "R" Drilling Co.*, 894 F.2d at 750 (holding employer did not meet its burden of showing that current total disability was not due solely to employment injury because it failed to put on medical evidence to suggest that claimant's pre-existing back diseases contributed to his current total back disability).

While Dr. Steinway's deposition testimony addressed a pre-existing osteoarthritic condition suffered by Claimant before his May 1991 work injury, Employer has failed to produce evidence that Employer had knowledge of the condition or, otherwise, medical evidence existed before 1991 documenting the osteoarthritic condition or making it objectively determinable. *See Esposito v. Bay Container Repair Co.*, 30 BRBS 67, 68 (1996); *Sealand Terminals, Inc., v. Gasparic*, 7 F.3d 321, 323 (2d Cir. 1993).

Accordingly, Employer is not entitled to Section 8(f) relief.

C. Conclusion

Claimant has demonstrated the presence of a permanent total disability arising from his work-related orthopaedic injuries. Accordingly, Claimant is entitled to permanent total disability benefits under the Act.

Employer has not demonstrated the existence and effect of pre-existing injuries. Accordingly, Employer is not entitled to Section 8(f) relief.

D. Attorney's Fees

As instructed by the Benefits Review Board, Claimant is entitled to the previously awarded attorney's fees as he has again demonstrated total disability. Claimant's counsel is allowed thirty days from the service date of this decision to file his attorney fee application, if appropriate, for work before this Court subsequent to my previous attorney's fees award. The application shall be prepared in strict accordance with 20 C.F.R. § 725.365 and 725.366. The application must be served on all parties, including the Claimant, and proof of service must be filed with the application. The parties are allowed thirty days following service of the application to file objections to the application for an attorney's fee.

ORDER

Based on the above findings of fact and conclusions of law, it is hereby ORDERED that Juan Almanzar is entitled to the compensation listed below as a result of the claim involved in this proceeding. The specific computations of the award and interest shall be administratively performed by the district director.

1. Employer/Administrator shall pay to Juan Almanzar compensation for permanent total disability at the rate of $464.94 per week beginning November 6, 1995. *See* 33 U.S.C. §908(a).

2. Employer shall be entitled to a credit for all payments of disability compensation already made to Mr. Almanzar under the Act.

3. Interest shall be paid on all accrued benefits in accordance with the rate applicable under 28 U.S.C. § 1961, computed from the date each payment was originally due, until paid. The appropriate rate shall be determined as of the filing date of this decision with the district director.

4. Employer shall furnish reasonable, appropriate and necessary medical care to Mr. Almanzar as required by Section 7 of the Act.

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JOSEPH E. KANE
Administrative Law Judge